EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

STATE EMPLOYEE INJURY COMPENSATION TRUST FUND (SEICTF)

Submit the online version of this form when possible by accessing our website at www.riskmgt.alabama.gov. This report is to be completed by a supervisor or other designated authority and faxed along with the Accident Report - Employee Statement form to 334-223-6170 or 888-827-6753 between 8 AM and 5 PM, Monday thru Friday. If you need assistance contact SEICTF at 800-388-3406. All questions must be answered. Please type or print information on this form.

1. Name of Injured Employee
Last First MI

2. SSN

3. Date of Birth
____/____/____

4. Sex
____ **M** ____ **F**

5. Home Address
No. and Street
City or Town
State Zip

6. Phone Home _____
Work _____
Cell _____
Work Hours: From: _____ To: _____

7. Job Title

8. Status _____ **Full Time**
_____ **Part Time**
_____ **Contract**

9. Job Code

10. Employing Agency - Agency Number

11. Division, District, etc.

12. Agency Address - Number and Street City or Town State Zip

13. Date of Injury
_____/_____/_____

14. Date Employer Notified
_____/_____/_____

15. Time of Injury
_____ ____ AM ____ PM

16. Is employee covered by State Employee Medical Insurance?
_____ **Yes** _____ **No**

17. Has the injury or illness resulted in medical treatment? If Yes, name and address of medical provider/facility.
_____ **Yes** _____ **No**

18. Exact location where injury occurred include street address, building, room, parking lot etc., if possible.

19. Was injury caused by a motor vehicle accident?
_____ **Yes** _____ **No**

20. Was more than one person injured in this incident?
_____ **Yes** _____ **No**

21. Describe the specific activity the employee was performing at the time the event or exposure occurred and what happened to cause the injury. Indicate the body part(s) affected.

22. Could this accident have been prevented? If yes, what steps have been taken to prevent another accident?
_____ **Yes** _____ **No**

23. Name all witnesses:

Name _____ **Daytime Phone** _____

Name _____ **Daytime Phone** _____

I am the supervisor of the employee making the claim for SEICTF benefits and have filled out this First Report of Injury based on the information that has been reported to me. I certify that the above information is true and correct to the best of my knowledge.

24. Signature of supervisor reporting incident Print Name Daytime Phone Date